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A HEALTH POLICY ANALYSIS OF PHARMACOTHERAPY FOR MAJOR DEPRESSIVE DISORDER IN EUROPE AND THE AMERICAS

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OBJECTIVE: We conducted a multi-national pharmacoeconomic analysis of oral therapies in the management of major depressive disorder (MDD) in 10 countries located in Europe, Latin America, and North America. The study was performed by an independent group of researchers under an unrestricted grant from Wyeth-Ayerst Laboratories. Data used to populate country-specific decision analytic models were derived from an international meta-analysis, a Delphi panel (conducted in each country to ascertain local practice patterns), and a financial analysis to valuate resources consumed with local currencies. Health care system information was collected in order to model pharmacoeconomic and net economic endpoints.
METHODS: We performed a patient-level pharmacoeconomic evaluation of MDD using a decision analytic approach. We then applied the pharmacoeconomic results at the policy level to calculate the net economic (budgetary) impact of shifting medical prescribing practice to the most cost-effective therapy. The perspective for the analysis was that of the public payor (i.e., government) for all countries studied except for the US, where the managed care perspective was evaluated.
RESULTS: When weighted by population size, the 10-country average expected cost of treatment of major depression with venlafaxine is US$3,750 per patient, compared to US$4,460 for SSRIs and US$4,630 for TCAs. Thus, treatment of major depression with venlafaxine presents substantial per-patient cost savings compared to SSRIs (US$710) and TCAs (US$880). Direct costs evaluated include the cost of pharmacuetical agents, physician services, laboratory services, and hospitalization. The expected cost savings attributible to venlafaxine are a function of a reduced requirement for health care services.
CONCLUSIONS: The net economic impact of a 1% shift in venlafaxine utilization in the 10 countries studied translates to a savings of US$14.24 million in total direct cost to society and a US$7.74 million in direct cost to the primary payers. The results withstand comprehensive sensitivity analysis.

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UTILIZATION PATTERNS OF ANTIDEPRESSANT MEDICATIONS IN A PATIENT POPULATION SERVED BY A PRIMARY CARE MEDICAL GROUP

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PURPOSE: The objective of this study was to assess utilization patterns of different antidepressants in patients served by a medical group using pharmacy claims data from two third-party insurers.
METHODS: Patients must have been 18 to 65 years of age, receiving a new prescription of anti-depressant between the period of 1994–1996. Definition of adequate dose and duration of anti-depressant therapy were based on 1993 AHCPR guidelines. Switching of therapy was defined when the patient discontinued the original antidepressant after addition of a second antidepressant, whereas augmentation was defined when the patient continued to purchase the original antidepressant at least once after addition of the second antidepressant. A dosage was considered titrated if the average daily dose for any of the first three prescriptions was different from any of the other two. All the analyses were performed based on the initial therapy.
RESULTS: The patient sample included 177 (18.8%) patients who received fluoxetine as initial therapy, 98 (10.4%) sertraline, 175 (18.6%) paroxetine, 373 (39.6%) tricyclic antidepressants (TCAs), and 119 (12.3%) other antidepressants. The treatment completion rate was: fluoxetine 18.6%, sertraline 14.3%, paroxetine 6.9%, TCAs 3%, and other antidepressants 7.6%. All of the pairwise comparisons vs. fluoxetine were statistically significant, except for the one with sertraline. The switch rate ranged from 5.6% for TCAs to 13.7% for paroxetine. No difference in augmentation rate was found among SSRIs (fluoxetine, 6.8%; sertraline, 4.1%; paroxetine, 5.7%), while the augmentation rate for fluoxetine was statistically significantly higher than TCAs (6.8% vs. 1.9%). The titration rate was 20.3% for fluoxetine, 28.1% for sertraline, 21.9% for paroxetine, 40.2% for TCAs, and 33.3% for other antidepressants (significant difference between TCAs and fluoxetine).
CONCLUSIONS: Our data have demonstrated that there were significant differences in utilization patterns among antidepressants. Much more attention must be paid to ensuring that newly treated patients achieve treatment completion.